TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
David L. Bruce, D.O.

Respondent Name
ACE American Insurance Company

MFDR Tracking Number
M4-15-2988-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
May 14, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: Submitted documentation does not include a position statement from the requestor. Accordingly, this decision is based on the information available at the time of review.

Amount in Dispute: $131.04

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "With regard to CPT code 99203, Respondent denied the request as the documentation does not support the level billed. The Provider was required to meet all three of the following: comprehensive history, comprehensive exam, and low complexity decision making. Not all of these elements were documented as required by the 1997 documentation guidelines for evaluation and management services. Therefore, reimbursement is not owed for CPT code 99203."

Response Submitted by: Downs-Stanford, P.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 30, 2014	Evaluation & Management, new patient (99203)	$131.04	$131.04

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.210 sets out the procedures for medical documentation.
3. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 15 – (150) Payer deems the information submitted does not support this level of service.

Issues

1. Is the insurance carrier's reason for denial of payment supported?
2. What is the maximum allowable reimbursement (MAR) for the disputed services?
3. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code 15 – "PAYER DEEMS THE INFORMATION SUBMITTED DOES NOT SUPPORT THIS LEVEL OF SERVICE." Documentation requirements are established by 28 Texas Administrative Code §133.210 which describes the documentation required to be submitted with a medical bill. 28 Texas Administrative Code §133.210 does not require documentation to be submitted with the medical bill for the services in dispute.

   Further, the process for a carrier's request of documentation not otherwise required by 28 Texas Administrative Code §133.210 is described in section (d) of that section as follows:

   > Any request by the insurance carrier for additional documentation to process a medical bill shall:
   > (1) be in writing;
   > (2) be specific to the bill or the bill's related episode of care;
   > (3) describe with specificity the clinical and other information to be included in the response;
   > (4) be relevant and necessary for the resolution of the bill;
   > (5) be for information that is contained in or in the process of being incorporated into the injured employee's medical or billing record maintained by the health care provider;
   > (6) indicate the specific reason for which the insurance carrier is requesting the information; and
   > (7) include a copy of the medical bill for which the insurance carrier is requesting the additional documentation.

   Review of the submitted documentation does not support that the insurance carrier made an appropriate request for additional documentation with the specificity required by §133.210(d). The Division concludes that carrier failed to meet the requirements of 28 Texas Administrative Code 133.210(d). The carrier's denial for this reason is not supported.

2. 28 Texas Administrative Code §134.203(c) states,

   > To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
   > (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83…
   > (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year…

   The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. The Division conversion factor for 2014 is $55.75.

   For procedure code 99203 on June 30, 2014, the relative value (RVU) for work of 1.42 multiplied by the geographic practice cost index (GPCI) for work of 1.000 is 1.420000. The practice expense (PE) RVU of 1.47 multiplied by the PE GPCI of 0.916 is 1.346520. The malpractice (MP) RVU of 0.13 multiplied by the MP GPCI of 0.816 is 0.106080. The sum of 2.872600 is multiplied by the Division conversion factor of $55.75 for a MAR of $160.15.

3. The total MAR for the disputed service is $160.15. The requestor is seeking $131.04. The insurance carrier paid $0.00. A reimbursement of $131.04 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $131.04.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $131.04 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	January 22, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.